MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

★ 10687

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 days
Hospital, Institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. ———
(If rural, give LOCATION)
2.(a) If veteran, name war ——— ✓

3. (a) FULL NAME: Waverly Anderton

3. (b) Social Security Number: ———

4. Sex: male
5. Color or race: black
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: unknown
——— 6.(c) If alive, give age —— years
7. Birth date of deceased (mo., day, yr.): 1896
8. AGE: Years 50 Months — Days — If less than one day ... hrs. ... min.
9. Birthplace: North Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business ———
FATHER 12. Name: Willis Anderton
13. Birthplace: North Carolina
MOTHER 14. Maiden name: Sally Burny
15. Birthplace: North Carolina
16. Informant: Hospital Records
Address: Crownsville State Hospital
17. (Burial, cremation, or removal. Which?) burial Date thereof 11/29-46 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md—
18. Funeral director: Supt. Hospital
Address: Crownsville Md
19. 11 Nov 19 46 (Date rec'd by registrar) E Joyce Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8 19 46 at 12:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 14 19 46 to November 8 19 46
and that I last saw him alive on October 8 19 46
Immediate cause of death: General Arteriosclerosis — DURATION: known to us since 10/14/46
Due to: ———
Due to: ———
Other conditions: ———
(Include pregnancy within 3 months of death)
Major findings of operation: ———
——— Date of op. ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ———
Means of injury ——— Injured at work? ———

23. SIGNATURE: Albert J. Winterode M. D. or other
Address: Crownsville, Maryland Date signed 11/8/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

2

★ 10688

Reg. Dist. No. 210

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
29 Thompson St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A. Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 29 Thompson St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Bean

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 25th 1906

8. AGE: Years	Months	Days	If less than one day
40	0	10	..... hrs. ..... min.

9. Birthplace: Baltimore Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Harry E. Bean
13. Birthplace: St. Marys Co. - Md.

MOTHER
14. Maiden name: E. Pearl Johnson
15. Birthplace: Harford Co. - Md.

16. Informant: Harry E. Bean
Address: 29 Thompson St. - Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 6 (month) (day) '46 (year)
Cemetery or crematory: Cedar Bluff Cemetery
Location: Annapolis Md.

18. Funeral director: John W. Taylor & Son
Address: Annapolis Md.

19. Nov. 4 1946 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 4 1946, at 6 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1946, to Nov 4 1946, and that I last saw h— alive on Oct 25 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2
Due to	
Due to	
Other conditions: Tuberculous Laryngitis (Include pregnancy within 3 months of death)	

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: M. J. Klawans MD
M. D. or other
Address: 31 Southgate Ave — Date signed: 11/4/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

10689

Reg. Diat. No. 280

1. PLACE OF DEATH: Anne Arundel

County

City or town: Crownsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 y. 6 m.

Hospital, Institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 11 y. 6 m.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Reisterstown (If outside city or town limits, write RURAL and give nearest town)

Street No.: Liberty Road (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Julia Berry

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 3, 1920

8. AGE: Years	Months	Days	If less than one day
26	11		..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Robert Berry

13. Birthplace

MOTHER 14. Maiden name: Helen Berry Madden

15. Birthplace

16. Informant: Hospital records

Address: Crownsville State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 3, 1946 (month) (day) (year)

Cemetery or crematory: St. Lukes

Location: Reisterstown, Md.

18. Funeral director: Wm. H. Holland

Address: 1631 Druid Hill Ave.

19. Dec. 8 1946 (Date rec'd by registrar) A. H. Holland Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 30 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1935 to Nov. 30 1946 and that I last saw h.. alive on Nov. 30, 1946

Immediate cause of death	DURATION
Idiopathic Epilepsy	11 y.
Due to	6 m.
Due to	
Other conditions: Psychosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address Date signed

VS A15 9.45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45)

CERTIFICATE OF DEATH

2

10690

Reg. Dist. No. 260

1. PLACE OF DEATH:
County: Churchton (Anne Arundel)
City or town: Maryland (Churchton)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Churchton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: MATTIE BOARDLEY

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Colored	Widow

6.(b) Name of husband or wife: John C. Boardley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1884

8. AGE: Years: 62? Months: Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: ? Robinson
13. Birthplace: Va.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Va.

16. Informant: James Boardley
Address: Churchton, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Nov 7 1946 (month) (day) (year)

Cemetery or crematory
Location: Virginia

18. Funeral director: W. Ernest Jarvis Co.
Address: 1432 You St. N. W. Wash D.C.

19. Nov 7 1946 (Date rec'd by registrar) J. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 11-7-46, at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 2 1946 to 11-7 1946 and that I last saw her alive on 11-7 1946

Immediate cause of death	DURATION
Cancer of throat with metastasis to	
Due to Lungs	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Cancer
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Geo. L. Adams M. D. or other
Address: Churchton md Date signed 11-7-47
1520 9th St NW. Wash D.C.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (732)

CERTIFICATE OF DEATH

2 ★ 10691 330

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING VS-A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Linthicum Heights, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maruland County: Anne Arundel
City or town: Linthicum Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 304 West Hawthorne Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mary L. Bradley MARY F. BRADLEY
3. (b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: WILLIAM BRADLEY
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): 9th Sept. 1865

8. AGE: Years: 81 Months: 1 Days: 23 If less than one day: hrs. min.

9. Birthplace: Nova Scotia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: Hugh Fraser
13. Birthplace: Scotland

MOTHER
14. Maiden name: Isabella Fraser
15. Birthplace: Scotland

16. Informant: Wm. H. Bradley
Address: 304 West Hawthorne Road

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 5 Nov. 1946 (month) (day) (year)
Cemetery or crematory: Greenwood
Location: Superior, Wisconsin

18. Funeral director: W. J. Tickner & Sons
Address: North & Pennsylvania Ave., NW
Baltimore, Md

19. 2 Nov. (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 5 1946, at 1 : 30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 1938, to Nov. 5 1946 and that I last saw h[illegible] alive on Nov. 5 1946

Immediate cause of death	DURATION
Cardio-Vascular Disease	2 yrs.
Cardio-vascular disease	
Due to	
Due to	
Other conditions: Bronchial Asthma	10 yrs.
Bronchial asthma	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas. L. Ball M. D. or other
Address: Linthicum Charles L. Ball, M.D.; Date signed: 11-2-46

2-35

Evidence for the change of age and birthplace is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46

CERTIFICATE OF DEATH

10692

Reg. Dist. No. 23

FILM No. I-08 NOV 21 1946

1. PLACE OF DEATH

County: A.A. Co.

City or town: Ferndale Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A.A. Co.

City or town: Ferndale Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 Eugenia Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frank Braun

3.(b) Social Security Number 215-10-4000

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed

6.(b) Name of husband or wife: Late Lillie

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 14 - 1881 - 1887

8. AGE: Years	Months	Days	If less than one day
59 65.	0	4	..... hrs. ..... min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Shipping Clerk.

11. Industry or business: Enbridge Co.

MOTHER FATHER

12. Name: Paul Braun

13. Birthplace: Baltimore Md.

MOTHER

14. Maiden name: Unknown

15. Birthplace: Baltimore Md.

16. Informant: Mrs Florence Feld

Address: 10 Eugenia Ave, Ferndale Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof 11-21-46 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: 3801 Frederick Ave

18. Funeral director: John J. Cooney & Son

Address: 901-03 Hollins St.

19. Nov. 19 1946 A. H. Hessert Registrar

(Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 18, 1946, at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1, 1946 to Nov 18 1946 and that I last saw h.m alive on Nov 18, 1946

Immediate cause of death	DURATION
Carcinoma of Oesophagus	2 mths
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: Salonfeld Injured at work?

23. SIGNATURE: Paul Helpfell M.D. M. D. or other

Address: No 1 Amph'h Date signed 11/18/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-7)

CERTIFICATE OF DEATH

10693

Reg. Dist. No. 25 0

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Arnold (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred: Shorewood Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Same County: A. A.

City or town: Same (If outside city or town limits, write RURAL and give nearest town)

Street No.: Same (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Isidore Anthony Burkhardt

3. (b) Social Security Number: 218-05-4082

4. Sex: M.

5. Color or race: W.

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mrs. Mary K. Morgan

6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): June 13 - 1889

8. AGE: Years 57, Months 5, Days 1; If less than one day ... hrs. ... min.

9. Birthplace: Baltimore, Md (Town, county, and state)

10. Usual occupation: Tallyman

11. Industry or business

FATHER 12. Name: Joseph Burkhardt

13. Birthplace: Germany

MOTHER 14. Maiden name: Valeria Burkhardt

15. Birthplace: Germany

16. Informant: Mrs. Mary Burkhardt

Address: Arnold, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 18 - 46 (month) (day) (year)

Cemetery or crematory: Holy Cross Brooklyn Md

Location: Gov Ritchie Highway

18. Funeral director: Milton Schilling

Address: 3914 Hanover cor Bristol Ave Zone 25

19. Nov 15 1946 (Date rec'd by registrar) Ida M. Whitem Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14 1946, at 2:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1st 1944, to Nov. 14 1946, and that I last saw him alive on Nov. 12 1946

Immediate cause of death: Cystic malignancy of the pancreas. DURATION: ?

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations: Cystic malignancy of the pancreas. Date of op. 8/23/44

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Gustave H. Fischer M.D. M. D. or other

Address: 5 - First Ave S.E. Glen Burnie, Md

Date signed: 11/14/46

1-31

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(83a)

★ 10691

Reg. Dist. No. 280

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 4 mo., 16 da.
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 yr., 4 mo., 16 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: WILLIAM H. CHASE

3.(b) Social Security Number: ----

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
male	black	widowed

6.(b) Name of husband or wife: ----------
6.(c) If alive, give age: -- years

7. Birth date of deceased (mo., day, yr.): 1877 (?)

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
appr. 70	--	--		

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: ------

FATHER
12. Name: Bob Chase
13. Birthplace: Maryland

MOTHER
14. Maiden name: Maggie Bean
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) burial Date thereof 12/7/46 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Superintendent
Address: Crownsville

19. (Date rec'd by registrar) 12-7 1946 E. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 1946 at 8:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1944, to Nov. 25 1946 and that I last saw h... 1m ...alive on November 25 1946

	DURATION
Immediate cause of death: Cerebral hemorrhage	1 day
Due to:	
Due to:	
Other conditions: Senile Psychosis known to us since 7/10/44	

(Include pregnancy within 3 months of death)

Major findings of operations: ----------
Date of op.: ---
Autopsy results: ----- --
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of: ----
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -------
Means of injury: -------- Injured at work? ----

23. SIGNATURE: Ward J. Chinchard M. D. or other
Address: Crownsville, Maryland Date signed: 11/26/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-a)

CERTIFICATE OF DEATH

10695

Reg. Diat. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One hour 38 minutes

Hospital, Institution, or street address where death occurred: Dispensary "A", Fort George G. Meade, Maryland

How long in hospital or institution? One hour 38 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Kansas County:

City or town: Iola
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 2
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

GARY LEE CONNER

3. (b) Social Security Number

–

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Newborn infant

6.(b) Name of husband or wife: –

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): 12 November 1946

8. AGE: Years	Months	Days	If less than one day
–	–	–	One hrs. 38 min.

9. Birthplace: Fort Geo. G. Meade, Anne Arundel, Md.
(Town, county, and state)

10. Usual occupation: –

11. Industry or business: –

FATHER
12. Name: Marvin L. Conner
13. Birthplace: Iowa, Kansas

MOTHER
14. Maiden name: Marjorie P. Prentice
15. Birthplace: Iowa, Kansas

16. Informant: Medical Records
Address: Fort George G. Meade, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/13/43 (month) (day) (year)

Cemetery or crematory: Post Cemetery

Location: Fort George G. Meade, Md.

18. Funeral director: Howard M. Blight Jr.

Address: 4914 Belair Road, Baltimore 6, Md.

19. 12 November 1946 (Date rec'd by registrar) BERNARD F. KERWIN, Capt, Registrar

PC

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 November 1946 at 0800 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 0622 12 November 1946 to 0800 12 Nov. 1946 and that I last saw him alive on 12 November 1946

Immediate cause of death	DURATION
Spina bifida	
Hydrocephalus	
Due to	
Due to	
Other conditions: Bilateral Halux Valgus	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.: –

Autopsy results: None performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Eugene N Wright

EUGENE N. WRIGHT, 1ST LT, M. D. or other M. C.

Address: Disp. "A", Ft. Geo. G. Meade, Md. Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

CERTIFICATE OF DEATH

10696

Reg. Dist. No. 210

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 Years
Hospital, institution, or street address where death occurred: 47 Fleet Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 47 Fleet Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ********

3.(a) FULL NAME: Katie Virginia Conor

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March ********* 28, 1865

8. AGE: Years	Months	Days	If less than one day
******* 81	7 *	***** 14	hrs. min.

9. Birthplace: Baltimore Co. (Town, county, and state)
10. Usual occupation: Maid
11. Industry or business: None

FATHER
12. Name: William Parks
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Bessie Simpkins
Address: 47 Fleet Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11- 17- 1946 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street

18. Funeral director: Ethel L. Hicks
Address: 43-45 Northwest Street

19. Nov. 16 19 46 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 12th 19 46 at 1:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 19 46, to Nov 12th 19 46.
and that I last saw h... alive on Nov 11th 19 46.

Immediate cause of death: coronary occlusion — DURATION: 14 y
Due to: arteriosclerosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edith Roeller, M.D. M. D. or other
Address: 42 State Circle, Annapolis, Md. Date signed: 11-14-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (846)

CERTIFICATE OF DEATH

10697

Reg. Dist. No. 28 C

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs, 2 mo. 11 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 2 yrs, 2 mo. 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico County

City or town: Mardela Springs
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ———
(If rural, give LOCATION)

2.(a) If veteran, name war: ———

3.(a) FULL NAME: Howard Cook

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Single

6.(b) Name of husband or wife: ———

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): Jan. 3, 1920

8. AGE: Years	Months	Days	If less than one day
26	10	6	...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ———

FATHER
12. Name: Clarence Cook
13. Birthplace: Maryland

MOTHER
14. Maiden name: Virgie Quinton
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 12 (month) (day) (year)

Cemetery or crematory: San Domenyo Cemetery

Location: Maryland

18. Funeral director: J.J. Frampton Son

Address: Federalsburg Md.

19. Nov. 9, 1946 (Date rec'd by registrar) E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 9 19 46 at 2:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29 19 44, to November 9 19 46 and that I last saw him alive on November 9 19 46

Immediate cause of death: Schizophrenia Simple Type — DURATION: known to us since 8/29/44

Due to: ———

Due to: ———

Other conditions: ———

(Include pregnancy within 3 months of death)

Major findings of operations: ———

Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ———

Means of injury ——— Injured at work? ———

23. SIGNATURE: Herbert J. Pinkerton M. D., or other

Address: Crownsville, Maryland Date signed: Nov. 9

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

#8869
Cook - Howard
Wicomico County
Readmitted - August 29, 1944
Died - November 9, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★10698

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: a. a.

City or town: annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years

Hospital, institution, or street address where death occurred:

6 Jefferson St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: annapolis.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 6 Jefferson

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Graham Crandall

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Martha Ellen Crandall

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): July 29 1898

8. AGE:

Years	Months	Days	If less than one day
48	3	29	...hrs. ...min.

9. Birthplace: Shadyside md (Town, county, and state)

10. Usual occupation: Auto. mechanic

11. Industry or business

FATHER

12. Name: Louis a Crandall

13. Birthplace: Shadyside - md

MOTHER

14. Maiden name: Elizabeth a Mayo

15. Birthplace: Shadyside md

16. Informant: Martha Ellen Crandall

Address: 6 Jefferson St. annapolis

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Nov 30/46 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis. Md

18. Funeral director: B T Hopkins & Son

Address: annapolis. Md

19. Nov. 29, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 28, 1946 at Bath M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1, 1946 to Nov. 28, 1946 and that I last saw h... alive on Nov. 28, 1946

Immediate cause of death	DURATION
Coronary Thrombosis	Instant.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ...Injured at work?

23. SIGNATURE: Albert L. Anderson MD. M. D. or other

Address: Annapolis, Md Date signed: 11/30/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

CERTIFICATE OF DEATH

10699

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: A.A.

City or town: Odenton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: A.A.

City or town: Odenton Md. (If outside city or town limits, write RURAL and give nearest town)

Street No.: Central Ave. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Grace B. Davis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Walter T. Davis

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 25, 1876

8. AGE:

Years	Months	Days	If less than one day
70	6	28	..... hrs. ..... min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER — 12. Name: Azriel Howard

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: ?

MOTHER — 15. Birthplace: —

16. Informant: Mrs Evelyn Talbott

Address: Odenton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 25/46 (month) (day) (year)

Cemetery or crematory: Ryon Cemetery

Location: Odenton Md

18. Funeral director: A. D. Stinchcomb

Address: Laurel Md.

19. Nov 26 1946 (Date rec'd by registrar) Clara Kaslick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 23rd 1946 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1st 1946 to Nov. 23rd 1946 and that I last saw her alive on Nov. 23rd 1946

Immediate cause of death	DURATION
Myocardial Insuff.	1 month
Due to Hypertensive Cardio-Vas. Disease	5 yrs.
Due to Diabetes	20 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Frank Shipley M.D. (M.D. or other)

Address: Savage Md. Date signed: 11/24/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS/A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (162a)

CERTIFICATE OF DEATH

★ 10700

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all her life
Hospital, Institution, or street address where death occurred: 102 South St Annapolis md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 102 South St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Susie Davis

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	col.	Widow

6.(b) Name of husband or wife:
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 1857

8. AGE: Years: 89 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: West River A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: Unknown
13. Birthplace: West River A. A. Co Md.

MOTHER
14. Maiden name: Mary Turner
15. Birthplace: West River A.A. Co. Md.

16. Informant: Mrs Mary I. Cook
Address: 16 Taylor St Annapolis Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 11-29-46 (month) (day) (year)
Cemetery or crematory: Rosemary Hill Cemetery
Location: West St. Ext. Annapolis Md

18. Funeral director: Mrs Charles D. Hicks
Address: 45 Northwest St Annapolis md.

19. Nov 29 1946
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-25 1946, at 2.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-9- 1946, to 11-25 1946 and that I last saw her alive on 11-25 1946

	DURATION
Immediate cause of death: Senile Dementia	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A. T. Allen Jr MD
M. D. or other
Address: 17 Carroll St. Date signed: 11-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46a)

CERTIFICATE OF DEATH ★

10701 Reg. Dist. No. 2-31

1. PLACE OF DEATH: County Anne Arundel; City or town Odenton Md (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Odenton R F D (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Benjamin Edwards

3.(b) Social Security Number 214-12-4154

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	~~married~~ Widowed

6.(b) Name of husband or wife Catherine Edwards deceased
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years 70 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Odenton A.A.Co Md (Town, county, and state)
10. Usual occupation laborer
11. Industry or business
FATHER 12. Name Samuel Edwards
13. Birthplace Anne Arundel Co Md
MOTHER 14. Maiden name Mary E Mathews
15. Birthplace Anne Arundel Co Md
16. Informant Annie Howard (daughter)
Address Odenton Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 8 1946 (month) (day) (year)
Cemetery or crematory Macedonia
Location Odenton, Md
18. Funeral director J. B. Johnson
Address Annapolis
19. Nov. 7, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 4 1946 at 11:57 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10 1946 to Nov 4 1946 and that I last saw him alive on Sept 22 1946

Immediate cause of death	DURATION
Due to Cancer of throat	7 Mo
Due to Carcinoma of Esophagus	7 Mo
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE O H McNemar M. D. or other
Address Millersville Md Date signed 11/4/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

7-230

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10702

Reg. Dist. No. 25

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, Institution, or street address where death occurred:
Seventh Ave. & Ritchie Highway
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5 Seventh Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Isaac H Foreman

3.(b) Social Security Number: 218-14-9906

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Elizabeth C Foreman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 4th 1879

8. AGE: Years: 67 Months: 0 Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Painter

11. Industry or business: Reveria Copper & Brass Works

FATHER
12. Name: John Foreman
13. Birthplace: Va

MOTHER
14. Maiden name: Rachel Goode
15. Birthplace: Va

16. Informant: Mr James Foreman
Address: 1428 L. Street S.E Washington D.C

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 30-46 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Washington D.C - S.E

18. Funeral director: Milton Schilling
Address: 3914 Hanover ST - 25 Md

19. Nov. 29 19 46 (Date rec'd by registrar) Ida M. Whitmore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 28 19 46 at 12-10 A M

21. I CERTIFY that death occurred ~~on the date above stated; that I attended deceased from~~ Post Mortem Examination Nov. 28 19 46

Immediate cause of death	DURATION
Crushed Chest	
Due to: Hemorrhage	
Due to: Hit by automobile	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

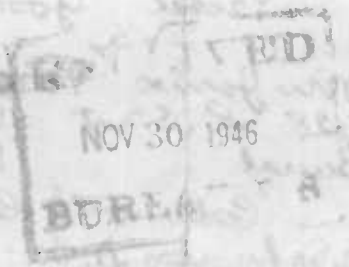
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 11/28/46
Where did injury occur? Brooklyn Park, A.A. Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Cor. Seventh Ave. & Ritchie Highway
Means of injury: Hit by automobile Injured at work? No. Coroner Medical Examiner

23. SIGNATURE: John M. Clatty M.D.
M. D. or other
Address: Annapolis, Md. Date signed: 11/28/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



4-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (123)

CERTIFICATE OF DEATH

10703 Brent

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel.

City or town: P.O. Pasadena

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 8 months.

Hospital, Institution, or street address where death occurred: — Rock Creek - off Water Oak Point

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: California County:

City or town: Long Beach.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Linda Faye Forsman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 12 - 1945

8. AGE:

Years	Months	Days	If less than one day
1	8	24	hrs. min.

9. Birthplace: Long Beach - California (Town, county, and state)

10. Usual occupation: None.

11. Industry or business

FATHER

12. Name: James Willard Forsman

13. Birthplace: Washington State.

MOTHER

14. Maiden name: Helen May Murray

15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Helen Forsman (mother)

Address: Water Oak Pt. - P.O. Pasadena, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof NOV 9-46 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Balto Md

18. Funeral director: Bernard C Harle

Address: 121 E West St

19. 11/8 1946 A.W. Hedrick Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November - 7 1946, at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...

and that I last saw h... alive on ..... 19...

Immediate cause of death: accidental drowning — DURATION: Sudden

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 11/7/46

Where did injury occur? Water Oak Pt. (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Rock Creek -

Means of injury: Drowning Injured at work? No

23. SIGNATURE: Gustave H Paulsen M.D. (attending physician) (M. D. or other)

Address: Glen Burnie Md. Date signed 11/7/46

3821 Passport
KERRY

Evidence for the changeof year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93d)

10704

FILM No. I 08 DEC 5 1946

CERTIFICATE OF DEATH

Reg. Diat. No. 21 0

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural (Annapolis, Maryland)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? seven (7) years

Hospital, Institution, or street address where death occurred:
U.S.N. Hospital, Annapolis, Maryland

How long in hospital or institution? seven (7) hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. # 3
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

MINNIE ELIZABETH FUNK

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Kenneth Waldo Funk

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): 27 December 1904 ~~1902~~

8. AGE: Years	Months	Days	If less than one day
43 ~~4 3~~	10	25	hrs. min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Charles H. Steinbraker
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: (unknown) Hess
15. Birthplace: Washington, D.C.

16. Informant: Husband
Address: RFD #3, Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 26 1946
(month) (day) (year)

Cemetery or crematory: Glenwood Cemetery

Location: Washington D.C.

18. Funeral director: The S.H. Hines Co.

Address: 2901 14th St NW Washington D.C.

19. Nov 22 1946
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 November 1946, at 12.55a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 21 November 1946, to 22 November 1946 and that I last saw her alive on 22 November 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	8 hr.
Due to: Hypertensive Cardio Vascular Disease.	5 to 6 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

R.H. Parker

23. SIGNATURE: R. H. Parker, Cdr MC USN
M. D. or other

Address: USN Hospital, Annapolis, Md. Date signed: 11-22-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1048)

CERTIFICATE OF DEATH

★ 10705

Reg. Diat. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Linthicum Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death: Valley Associates 1 Yr

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Linthicum Heights

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Valley & Arundel Rds.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: John S Hager

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Mary C

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb 22 1874

8. AGE:

Years	Months	Days	If less than one day
72	8	2	..... hrs. ..... min.

9. Birthplace: New York (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business:

FATHER — 12. Name: John S Hager

13. Birthplace: New York

MOTHER — 14. Maiden name: Mary Dimlong

15. Birthplace: Germany

16. Informant: Mrs Mary Hager

Address: Linthicum Heights

17. (Burial, cremation, or removal): Burial Date thereof: 11-27-46 (month) (day) (year)

Cemetery or crematory: Baltimore Md

Location: Baltimore Md

18. Funeral director: Geo A Fuhrman

Address: Catonsville Md

19. Nov. 27 1946 (Date rec'd by registrar) M. E. Walla Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 24 1946, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 28 1946, to Nov. 24 1946, and that I last saw him alive on Nov. 24 1946.

Immediate cause of death	DURATION
Thrombosis Coronary Disease	2 yrs.
Terminal —	
Due to	
Due to	
Other conditions Arterio sclerosis	2 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas. L. Bare Jr MD M. D. or other

Address: Linthicum ..... Date signed: 11-26-46

1-35

2-270 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

10706

Reg. Dist. No. 201

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Galesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 68 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Galesville Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Susan Virginia Hartge

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Emile A Hartge
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 13, 1856

8. AGE:

Years	Months	Days	If less than one day
90	4	16	..... hrs. ..... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Capt. Thomas Edgar
13. Birthplace: Dorchester Co Maryland

MOTHER
14. Maiden name: Susan A Harper
15. Birthplace: Dorchester Co Maryland

16. Informant: Susan E Hartge
Address: Galesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 1 1946 (month) (day) (year)
Cemetery or crematory: Quaker Cem.
Location: Galesville Md.

18. Funeral director: F. A. Hardesty & Son
Address: Galesville Md

19. 12/1 1946 (Date rec'd by registrar) W. M. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 29 1946 at 10 A.M

21. I CERTIFY that death occurred on the date above etated; that I attended deceaeed from Nov. 1 1946, to Nov. 29 1946
and that I laet eaw h.. alive on Nov. 26 1946

Immediate cause of death	DURATION
Angina Pectoris	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Emily H. Wilson, M.D. (M. D. or other)
Address: Tolliver, Md Date signed: 12/1/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(97) ★ 10707

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 33 years, 6 mo., 12 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 33 years, 6 mo., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infante give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Washington Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

3.(a) FULL NAME: SARAH JANE HAWKINS

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: ———
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): unknown to us

8. AGE: Years	Months	Days	If less than one day
appro. 82	—	—	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business: ———

FATHER
12. Name: ———
13. Birthplace: ———

MOTHER
14. Maiden name: ———
15. Birthplace: ———

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 1, 1946 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis, Maryland

18. Funeral director: J. B. Johnson
Address: Annapolis, Maryland

19. Dec 1, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 25 1946, at 1:25P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 1913 to Nov. 25 1946 and that I last saw her alive on Nov. 25, 1946

	DURATION
Immediate cause of death: General Arteriosclerosis known to us since May 13 1913	
Due to:	
Due to:	
Other conditions: Senile Psychosis known to us since May 13, 1913 (Include pregnancy within 3 months of death)	

Major findings of operations: ———
Date of op. ——
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ———
Means of injury ——— Injured at work? ———

23. SIGNATURE: Ethel V. Hinebaugh M. D. or other
Address: Crownsville, Maryland Date signed 11/25/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

10708

Reg. Diat. No. 231

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Odenton, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 months
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Patuxant Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FRANK HENSLEY

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widower

6.(b) Name of husband or wife: Hester Hensley Pate
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): May 1 1891

8. AGE: Years	Months	Days	If less than one day
55	6	11	hrs. min.

9. Birthplace: Yancy Co., North Carolina (Town, county, and state)
10. Usual occupation: Farmer (Retired)
11. Industry or business

FATHER
12. Name: William Hensley
13. Birthplace: Yancy Co., North Carolina

MOTHER
14. Maiden name: Mary Lewis
15. Birthplace: Yancy Co., Norht Carolina

16. Informant: Floyd Hensley
Address: Odenton, Md.

17. Ship for burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 17, 1946 (month) (day) (year)
Cemetery or crematory:
Location: Huntdale, N. C.
18. Funeral director: Thomas W. Livingston
Address: Glen Burnie, Md.

19. Nov. 16 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 16 1946, at 9:15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 1946, to Nov 16 1946, and that I last saw h... alive on Nov 14 1946.

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Hypertensive heart	10 yrs
Hemiplegia, Complete	10 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please nuderline the cause to which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Otmar Neuman M.D. M. D. or other
Address: Millersville Md. Date signed: 11/16-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

10709 26
Reg. Dist. No.

1. PLACE OF DEATH:
County Anne Arundel
City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore City
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 403 Parrish Street
(If rural, give LOCATION)
2.(a) If veteran, name war ------

3.(a) FULL NAME
FRANK JOHNSON

3.(b) Social Security Number
------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	unknown to us

6.(b) Name of husband or wife ------
------ 6.(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
61	--	--	....hrs. ....min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business ----

FATHER
12. Name William Johnson
13. Birthplace Unknown to us

MOTHER
14. Maiden name ------
15. Birthplace ------

16. Informant Hospital Records
Address Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 29 1946 (month) (day) (year)
Cemetery or crematory Mt. Auburn Cem
Location

18. Funeral director Mrs Kate R. Wellen
Address 3222 Schroeder st

19. 11-26 46 (Date rec'd by registrar) 19 ---- Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24 19 46 at 11:20 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 13 19 46 to Nov. 24 19 46 and that I last saw h... im ...alive on November 24 19 46

Immediate cause of death General Arteriosclerosis — DURATION known to us since Nov. 13, 1946

Due to .....

Due to .....

Other conditions Psychosis with cerebral arteriosclerosis — known to u since 11/13/4
(Include pregnancy within 3 months of death)

Major findings of operations ------ Date of op. ----

Autopsy results ------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ---- Date of ----
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ----------
Means of injury Injured at work?

23. SIGNATURE Wood J. Winterode M. D. or other
Address Crownsville, Md. Date signed 11/24/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

CERTIFICATE OF DEATH

10710

Reg. Dist. No. 210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mos. 10 Days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Virginia County: Campbell

City or town: Lynchburg (If outside city or town limits, write RURAL and give nearest town)

Street No.: 607 Peyton Street (If rural, give LOCATION)

2.(a) If veteran, name war: 2nd. World War (S)

3.(a) FULL NAME: Wyatt Albert JONES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Eula Ann JONES

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 10 July 1914

8. AGE: Years	Months	Days	If less than one day
32	4	13	....hrs. ....min.

9. Birthplace: Lynchburg- -Campbell- -Virginia (Town, county, and state)

10. Usual occupation: United States Navy

11. Industry or business

FATHER 12. Name: Unknown

FATHER 13. Birthplace

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace

16. Informant: U.S. Navy Service Record

Address: Naval Hospital Annapolis Md

17. Burial, cremation, or removal. Which?: Removal Date thereof: Dec 3/46 (month) (day) (year)

Cemetery or crematory:

Location: Lynchburg, Va

18. Funeral director: B.L. Hopkins & Son

Address: Annapolis, Md.

19. Dec. 3, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Approx. 27 Nov. 1946, at ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dead on arrival 19.. to .. 19..

and that I last saw h.. alive on Never seen alive by undersigned.

Immediate cause of death	DURATION
Drowning	
Due to: Alcoholism	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Autopsy results: Alcohol found in stomach + bladder contents. No evidence of violence. Date of op.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. Nathaniel Bush Jr. M.D. M.D. or other

Address: U.S. Naval Hosp. Annapolis, Md. Date signed: 12-2-46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1248)

CERTIFICATE OF DEATH

10711

Reg. Diat. No. 20 0

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Edgewater
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Woodland Beach - home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - Edgewater
(If outside city or town limits, write RURAL and give nearest town)

Street No. Woodland Beach - Arundel Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ida Louise Justice

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	M

6.(b) Name of husband or wife: William Arnold Justice

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Dec. 20, 1876

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
69	10	20		

9. Birthplace: Phila, Pa.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Jonafas Gruter
13. Birthplace: Pa.

MOTHER
14. Maiden name: Unknown
15. Birthplace: —

16. Informant: Wm. A. Justice
Address: Woodland Beach

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 13th 1946 (month) (day) (year)

Cemetery or crematory: Fort Lincoln

Location: Pri Geo Co Md

16. Funeral director: John M. Taylor Son

Address: Annapolis Md

19. Nov. 12 19 46 (Date rec'd by registrar) Edward Callaway Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 9 19 46, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ 19 , to 19

and ~~that I last saw h~~ alive on 19

Immediate cause of death	DURATION
Cardiac failure	
Due to: Portal cirrhosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Edward P. Ritchie, M.D.
M.D. or other acting M.E.

Address: 199 Gloucester St Annapolis Md. Date signed: Nov. 10, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

2

10712

Reg. Dist. No. 90 280

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1312 N. Mount St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ****

3.(a) FULL NAME: EVA KIAH

3.(b) Social Security Number: ----

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: *****
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1890 ?

8. AGE: Years	Months	Days	If less than one day
56 ?	-	-	....hrs. ....min.

8. Birthplace: ---- (Town, county, and state)
10. Usual occupation: ----
11. Industry or business: ----
FATHER 12. Name: ----
13. Birthplace: ----
MOTHER 14. Maiden name: ----
15. Birthplace: ----
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. buried (Burial, cremation, or removal. Which?) Date thereof: Nov. 3, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Auburn Cemetery
Location: Baltimore, Maryland
18. Funeral director: Mrs. George H. Holland
Address: 1631 Druid Hill Ave., Balto., Md.
19. 11/ 19 46 (Date rec'd by registrar) E.F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 1 19 46, at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 15 19 46, to Nov. 1 19 46
and that I last saw h...er...alive on Nov. 1 19 46

Immediate cause of death	DURATION
cardio-renal disease known to us since	10/15/46
Due to	
Due to	
Other conditions: Psychosis Known to us since Oct. 15, 1946	

(Include pregnancy within 3 months of death)

Major findings of operations: ----
Date of op. ----
Autopsy results: ----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of ----
Where did injury occur? ---- (City or town) ---- (County) ---- (State)
Injured at home, farm, industry, public place (where?): ----
Means of injury: ---- Injured at work? ----

23. SIGNATURE: Albert V. Bruneteau M. D. or other
Address: Crownsville, Maryland Date signed: Nov. 1

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169)

★ 10713

CERTIFICATE OF DEATH

Reg. Diat. No. 210

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Emergency Hospt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Edgewater

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Baby Boy Lee

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov - 13th 1946

8. AGE:

Years	Months	Days	If less than one day
—	—	-	7 hrs. 35 min.

9. Birthplace: Annapolis Md

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: Thomas E. Lee

13. Birthplace: A. A. Co. Md.

MOTHER — 14. Maiden name: Jeannette Burgess

15. Birthplace: A. A. Co. Md.

16. Informant: Thomas E. Lee

Address: Edgewater A. A. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 15th 1946 (month) (day) (year)

Cemetery or crematory: All Hallows

Location: Birdsville A. A. Co. Md.

18. Funeral director: John W. Taylor, Son

Address: Annapolis Md.

19. Nov. 15th 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 11-13- 1946, at 8 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-13- 1946, to 11-13- 1946

and that I last saw him alive on 11-13-46 19

Immediate cause of death: Prematurity — DURATION: 7 hrs. 35 m.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James R. Martin, M. D. M. D. or other

Address: 165 Prince George St. Annapolis Md. Date signed 11-14-46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-63

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

10714

Reg. Diat. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Greenhaven

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County B.A.C.

City or town Baltimore - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Green Haven -

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Charles C. Lovell

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Widower

6.(b) Name of husband or wife Caroline

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 15-1870

8. AGE: Years	Months	Days	If less than one day
76	5	8	hrs. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Charles Lovell

13. Birthplace Md.

MOTHER 14. Maiden name ✓

15. Birthplace ✓

16. Informant Miss Mary Lovell

Address 2615 Chesterfield Ave.

17. Burial Date thereof 11-26-46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Parkwood

Location Baltimore

18. Funeral director Leonard J. Ruck

Address 5305 Harford Rd.

19. 11-25 19 46 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 23-46 19 at 1.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15- 1946, to Nov 23-46 and that I last saw h alive on Nov 22-46

Immediate cause of death	DURATION
Uremia	
Due to Chronic Bright's Disease	
Due to	
Other conditions Vertigo + Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M.D. or other

Address Odenton Md Date signed Nov 23-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

2 10715

Reg. Dist. No. 210

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 5

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 217 Hanover St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Dorothea Chess Marshall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Robert M. Marshall
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 7th 1890

8. AGE: Years 56 Months 4 Days 25 If less than one day hrs. min.

9. Birthplace Pittsburgh. Pa
(Town, county, and state)

10. Usual occupation
11. Industry or business

FATHER
12. Name David W. Chess
13. Birthplace Pittsburgh Pa

MOTHER
14. Maiden name Mary Stowe Boles
15. Birthplace Penn.

16. Informant Mrs. Mary Chess Heffron
Address 217 Hanover St. Annapolis Md.

17. Removal Date thereof Nov 3rd 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory
Location Pittsburgh Pa

18. Funeral director John M. Taylor. Son
Address Annapolis Md.

19. Nov 3, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1946, at 1.45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 7 1946, to Nov 1 1946
and that I last saw her alive on Nov 1 1946

Immediate cause of death	DURATION
Cardio Vascular Failure	12 hrs
Due to Cancer of Lung	Several months
Due to Cancer of Liver	"
Other conditions Cancer of Left Breast (Include pregnancy within 3 months of death)	Several yrs.

Major findings of operation Radical Removal
Radical Operation Left breast about 1940 Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Oliver Pierce M. D. or other
Address Annapolis Md. Date signed 11/2/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (66)

Registered No. 2388

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Md.
(b) Street address Old Anna Rd., 2000' north
(c) Hospital or institution: 2 Bellgrove Rd, North Linthicum.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED: 10716
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 1115 Briscoe Street (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME Edward Mason

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex: Male | 5. Color or race: Colored | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Eunice

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1907

8. AGE: Years 39 | Months | Days | If less than one day hr. min.

9. Birthplace Calvert Co., Md. (Town, county, and state)

10. Usual Occupation Laborer

11. Industry or business

FATHER
12. Name William Mason
13. Birthplace Calvert Co., Md.

MOTHER
14. Maiden Name Elizabeth Mason
15. Birthplace Calvert Co. Md.

16 (a) Informant Eunice Mason
(b) Address 1119 Briscoe St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12/2/46 (month) (day) (year)
(c) Cemetery or crematory Mt. Calvery
Location Brooklyn, Md.

18 (a) Funeral director Elroy A. Wilson
(b) Address 1000 Granby ave

19 (a) 12-2-46 (Date rec'd by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 24, 1946, at 10 55 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to Hse death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Shot gun wound of chest involving left lung.

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 9:30 P. at 11-24-46
(b) Where did injury occur Old Anna Rd., 2000' North 2 Bellgrove Rd North Linthicum
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Firearms - Shot gun

23. Signature Howard J. Lucas M.D. Medical Examiner.
Date signed 11-25-46

VS 151

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

530

★ 10717

Reg. Dist. No. 22

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Hanover Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs.

Hospital, institution, or street address where death occurred: Race Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Hanover, Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Lavina Matthews

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	Col.	Widowed.

6.(b) Name of husband or wife: Perry Matthews

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct ? 1879

8. AGE: Years: 67 | Months: 1 | Days: ? | If less than one day: hrs. min.

9. Birthplace: P. G. Co., Md. (Town, county, and state)

10. Usual occupation: Domestic.

11. Industry or business:

FATHER — 12. Name: Unknown

13. Birthplace: ✓

MOTHER — 14. Maiden name: Unknown

15. Birthplace: ✓

16. Informant: Frances Matthews

Address: Hanover, Md., R. F. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/26/46 (month) (day) (year)

Cemetery or crematory: St. Marks

Location: Ridge Rd.

18. Funeral director: Mrs. George H. Holland

Address: 1631 Arundel Hall Ave, Balto, Md

19. Nov 24 1946 (Date rec'd by registrar) Elana Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 23rd 1946 at 5a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 20th 1946 to Nov. 23rd 1946

and that I last saw her alive on Nov. 22nd 1946

	DURATION
Immediate cause of death: Cerebral Haemorrhage	3 Days
Due to: Hypertension	3 yrs.
Due to: Arterio-sclerosis	3 yrs.
Other conditions: ✓	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Maude E. Shipley M. D.

M. D. or other

Address: Savage, Md. Date signed 11/23/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (BD)

CERTIFICATE OF DEATH

10718

Reg. Dist. No. 21 0

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Emergency Hospt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 431 Fourth St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James J. McGrath

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret McGrath

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 11th 1866

8. AGE: Years	Months	Days	If less than one day
80			hrs. min.

9. Birthplace: Ireland (Town, county, and state)

10. Usual occupation: Engineer Ret.

11. Industry or business: Stetson Hat Co.

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace

16. Informant: Kendel L. Dougherty

Address: 431 Fourth St. Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov. 14th 1946 (month) (day) (year)

Cemetery or crematory: St Marys Cemt.

Location: Annapolis Md.

18. Funeral director: John M Taylor Son

Address: Annapolis Md.

19. Nov. 12 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 11 1946, at 6.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 — 1946, to Nov 11 1946

and that I last saw h[illegible] alive on Nov 11 1946

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Arteriosclerotic C.V. disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: M. D. or other

Address: Eastport Md. Date signed 11/12/46

M

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (103)

CERTIFICATE OF DEATH

10719 P

★

Reg. Dist. No. 21 Brent

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Lake Shore - P.O. Pasadena, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, Institution, or street address where death occurred: Baldwin Plains

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A.A.

City or town: Lake Shore - P.O. - Pasadena

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Baldwin Plains.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Muller (Muller)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Mr.	W.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May - 1865

8. AGE: Years: 81 | Months: 6 | Days | If less than one day: hrs. min.

9. Birthplace: Germany. (Town, county, and state)

10. Usual occupation: Cooker

11. Industry or business

FATHER 12. Name: Joseph Muller

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Annie Seiner

MOTHER 15. Birthplace: Germany.

16. Informant: Paul Muller (brother)

Address: Poplar Ridge - P.O. Pasadena.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/26/46 (month) (day) (year)

Cemetery or crematory: Sacred Heart

Location: German Hill Rd

18. Funeral director: Tilly & Zeller Sons

Address: 403 S. Wolfe St.

19. 11-25-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 23 19 46 at ? M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 to 19

and that I last saw him alive on — 19

	DURATION
Immediate cause of death: Circulatory diseases	Unknown
Due to: senility	?
Due to: P.S. was found dead in his home at 4 P.M.	
Other conditions: on 11/23/46	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Gustave A. Faulenbud M. D. or other

Address: Glen Burnie, Md. Date signed 11/22/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-2)

CERTIFICATE OF DEATH

10720

Reg. Diat. No. 21 0

1. PLACE OF DEATH: H. H.

County ..... Annapolis

City or town ..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: 19 Larkin st

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County A. Co.

City or town Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No. 19 Larkin (If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Benjamin S. Moore

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	widower

6.(b) Name of husband or wife Eliza Moore

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 2 1847

8. AGE: Years	Months	Days	If less than one day
99	8	4	..... hrs. ..... min.

9. Birthplace Va (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Wm H. Moore

13. Birthplace Va

MOTHER 14. Maiden name Sylvia Moore

15. Birthplace Va

16. Informant Eleanor McGinn Address Calvert st

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 12 1946 (month) (day) (year)

Cemetery or crematory Brewer Hill

Location Annapolis

18. Funeral director Patterson Address .....

19. Nov. 12 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 9 1946, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-4 1946, to 11-9 1946

and that I last saw h[illegible] alive on 11-8-46 1946

Immediate cause of death Hypostatic pneumonia

Due to Encephalopathy

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE A. T. Ellis M. D. or other

Address 17 Conduit St Date signed 11-11-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

10721

Reg. Dist. No. 280

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 7 mo., 12 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 yr., 7 mo., 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 9 Monument Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: CORA NASH

3.(b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: ------

6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): 1890

8. AGE: Years	Months	Days	If less than one day
56	---	---	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: -----

FATHER
12. Name: Lebin Nash
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah ?
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 11/19-46 (month) (day) (year)
Cemetery or crematory: Crownsville
Location: Hospital

16. Funeral director: Dabb F Hospital
Address: Crownsville Md

19 Nov 19 1946 E F Joyce Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 14 1946, at 9:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1945, to November 14 1946
and that I last saw her alive on November 14 1946

Immediate cause of death	DURATION
General Arteriosclerosis known to us since April 2, 1945	
Due to	
Due to	
Other conditions: Senile Psychosis known to us since April 2, 1945	

(Include pregnancy within 3 months of death)

Major findings of operations: -----
Date of op.: ---
Autopsy results: ------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ----- Date of: ---
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ------
Means of injury: ------ Injured at work: ---

23. SIGNATURE: Albert L. Kinnaird M. D. or other
Address: Crownsville, Maryland Date signed: 11/15/46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

10722

CERTIFICATE OF DEATH

Reg. Dist. No. 210

1. PLACE OF DEATH:

County A.A.

City or town Germantown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Months

Hospital, institution, or street address where death occurred:
Lo6 North Brewer Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Crownsville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frederick J. Pfingsten

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Elizabeth M, Pfingsten.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 28, 1874

8. AGE: Years	Months	Days	If less than one day
72	6	2I	..... hrs. ..... min.

9. Birthplace Baltimore, Md
(Town, county, and state)

10. Usual occupation REtired

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace ~~Uknown~~ Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Uknown

16. Informant Mrs William C, Pfingsten

Address I06 N. Brewer Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 2I I946 (month) (day) (year)

Cemetery or crematory Baldwin Memorial

Location Millersville, Md

18. Funeral director B.L.Hopping & Son

Address Annapois, Md.

19. Nov 2I 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 18 1946, at 6 P M

21. I CERTIFY that death occurred on the date above etated; that I attended deceaeed from July 1946, to Nov 18 1946 and that I last eaw h... alive on Nov 18 1946

Immediate cause of death	DURATION
Myocardial chr, with Myocardial Insufficiency	Several yrs
Due to Arter Sclerosis	Several yrs
Due to Hypertension	Several yrs
Other conditions Chr. Nephritis	Several yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Boal M. D. or other

Address ..... Date signed 11-20-46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

10723

Reg. Dist. No. 25-0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:
County Anne Arundel -
City or town Brooklyn Park -
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about - 22 years -
Hospital, institution, or street address where death occurred:
How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Brooklyn Park (Co. Zone 25)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 13 - Third Avenue -
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME George A. Phelps

3. (b) Social Security Number 218-07-8541-A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Clara V. Phelps - (nee Biggs) 6.(c) If alive, give age - years

7. Birth date of deceased (mo., day, yr.) November 10, 1864

8. AGE: Years 82 | Months - | Days 4 | If less than one day ... hrs. ... min.

9. Birthplace Savage, Howard Co., Md. (Town, county, and state)

10. Usual occupation Retired Textile Foreman

11. Industry or business Linen Thread Co. -

FATHER 12. Name William Phelps -

FATHER 13. Birthplace Savage, Howard Co., Md.

MOTHER 14. Maiden name Anne Lucretia Snowden

MOTHER 15. Birthplace Savage, Howard Co., Md.

16. Informant Miss Leola L. Phelps (Daughter)
Address 13 - 3rd Ave., Brooklyn Pk., 25, Anne Arundel Co., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov 16, 1946 (month) (day) (year)

Cemetery or crematory Savage Cemetery

Location Savage, Howard Co., Md.

18. Funeral director P. Howard Evans

Address 400 E. Chase St., Balto. 30, Md.

19. Nov 16 1946 Ida M. Whitson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 14, 1946, at 1:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1946, to Nov. 14 1946 and that I last saw him alive on Nov. 13, 1946

Immediate cause of death	DURATION
Chronic Myocarditis	6 mo.
Due to	
Due to	
Other conditions Acute Bronchitis	1 Week

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE P. J. Imwalle M. D. M. D. or other

Address 4609 Gov. Ritchie Hwy Date signed 11-15-46.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

10724

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A. A.

City or town Linthicum - Hgts.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo.

Hospital, institution, or street address where death occurred:
426 - Forrest View Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Same County

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME AS-KATIE J. ROBERTS
Catherine Cecelia Roberts

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife Sidney Roberts

6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) Feb. 19 1871

8. AGE: Years	Months	Days	If less than one day
75	9	1	...hrs. ...min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation Nun - Hsw.

11. Industry or business George W. Reed

FATHER
12. Name ~~James F Reese~~
13. Birthplace Baltimore Md.

MOTHER
14. Maiden name Ann Hunter
15. Birthplace Baltimore Md.

16. Informant JAMES F REESE

Address 426 FORREST VIEW RD.

17. Burial Date thereof 11/23/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Holy Cross

Location Annapolis Blvd - A.A.Co.

18. Funeral director John F Hennessy & Sons

Address 515 Light St. Baltimore

19. 11-22 1946
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 20 1946 at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1946 to Nov. 20 1946

and that I last saw h[illegible] alive on Nov. 20 1946

Immediate cause of death Cardiovascular Disease — DURATION 10 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Bacc Jr MD
M. D. or other

Address Linthicum Date signed 11-20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

10725 220

Reg. Dist. No.

1. PLACE OF DEATH:

County A. A. Co

City or town Odenton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County A. A

City or town Odenton
(If outside city or town limits, write RURAL and give nearest town)

Street No. Telegraph Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Minnie Rose

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife William T. E. Rose

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) Sept 25 1889

8. AGE: Years	Months	Days	If less than one day
57.	1	6	....hrs. ....min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name John Ittner
13. Birthplace Germany

MOTHER
14. Maiden name Eva Novak
15. Birthplace Germany

16. Informant William T. E. Rose
Address Odenton Md

17. Burial Date thereof Nov 4 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Nichols Memorial

Location Odenton Md

18. Funeral director Mr. & Mrs. John W. Teufel & Son

Address 511 Edmondson Ave.

19. 11/2 1946 A. W. Hobiel M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov 1 1946, at 2.9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19.... to — 19....

and that I last saw h... alive on — 19....

Immediate cause of death	DURATION
"Coronary occlusion"	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op....

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gustave A. Faulenbach Jr. M.D.
Assistant Medical Examiner M. D. or other

Address Glen Burnie Md Date signed 11/1/46

M

I

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

2

Reg. Dist. No. 10326 260

1. PLACE OF DEATH:

County Anne Arundel

City or town Rural - Shadyside
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Rural - Shadyside
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Beatrice Saunders

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	M

6.(b) Name of husband or wife James Saunders

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) ? 1903

8. AGE: Years	Months	Days	If less than one day
43			...hrs. ...min.

9. Birthplace Friendship A.A. Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Walter Roger
13. Birthplace Md.

MOTHER
14. Maiden name Molly Forester
15. Birthplace Md.

16. Informant James Saunders

Address Shadyside, Md.

17. burial Date thereof Nov 6 46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Friendship

Location Friendship

18. Funeral director T. A. Hardesty Hsn

Address Galesville Md

19. Nov 3 1946 D. B Dent
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Nov. 3 1946, at 7 00 A.M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ ...19..., to ...19...

~~and that I last saw h~~ alive on ...19...

Immediate cause of death	DURATION
Cardiac Failure	
Due to Coronary Thrombosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edward P. Ritchings, M.D.
M.D. or other

Address 199 Gloucester St. Date signed Nov 3 1946
Annapolis, Md.

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-a)

CERTIFICATE OF DEATH

10729

Reg. Diat. No. 210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information correctly. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Warren Schmoyer Jr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 22nd 1946

8. AGE: Years	Months	Days	If less than one day
		3	..... hrs. ..... min.

9. Birthplace: Annapolis Md

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: John Warren Schmoyer

13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Rose J. Miklencic

15. Birthplace: Penn.

16. Informant: John W. Schmoyer

Address: Eastport a c/o Md.

17. Burial, cremation, or removal: Removal — Date thereof: Nov 25th 1946 (month) (day) (year)

Cemetery or crematory: Cooperstown Pa

Location

18. Funeral director: John W. Taylor Son

Address: Annapolis Md.

19. Nov. 25 1946 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov 24 1946 at 12-40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 22 1946, to Nov. 24 1946

and that I last saw him alive on Nov 24 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	36 hrs
Due to: post partum delivery	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: J. Bussick MD (M. D. or other)

Address — Date signed

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49-a)

CERTIFICATE OF DEATH

10727

Reg. Dist. No. 210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: West Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 500 Severn Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Anne Arundel
City or town: West Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 500 Severn Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: May Metzger Shiley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Widow

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Oct 15th 1885

8. AGE: Years	Months	Days	If less than one day
61	1		...hrs. ...min.

9. Birthplace: Penn.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Unknown
13. Birthplace

MOTHER 14. Maiden name: Unknown
15. Birthplace

16. Informant: Miss Ethel Mae Shiley
Address: 500 Severn Ave W. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 18th 1946 (month) (day) (year)

Cemetery or crematory

Location: Highspire Penn.

18. Funeral director: J. Kim M. Taylor Co
Address: Annapolis Md.

19. Nov. 17 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 15 1946, at 1:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 1945, to Nov. 15 1946
and that I last saw h... alive on Nov. 13 1946

Immediate cause of death	DURATION
Generalized carcinomatosis	1 yr.
Carcinomatosis	
Due to: Carcinoma of breast (Lt.)	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. Bozeuch M.D. M. D. or other
Address: Annapolis Md Date signed: 11/16/46

1-3 J

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

CERTIFICATE OF DEATH

★ 10728

Reg. Diat. No. 210

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Near Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: N. Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Zeola Huston Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Dr Marshall J. Smith

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 26th 1870

8. AGE:

Years	Months	Days	If less than one day
76	1	16	..... hrs. ..... min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business

FATHER 12. Name: Jacob N. Coulbourne

FATHER 13. Birthplace: Delaware

MOTHER 14. Maiden name: Mary Leuetta Williams

MOTHER 15. Birthplace: Delaware

16. Informant: Mrs R. Leighman Bire III

Address: Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov 14th 1946 (month) (day) (year)

Cemetery or crematory: Bethel M.E Church Yard

Location: Bethel Delaware

18. Funeral director: John M. Taylor Son

Address: Annapolis Md.

19. Nov 12 1946 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 11-46 Zeola Huston Smith 19 46, at 7 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 1946, to Nov. 11 1946

and that I last saw her alive on Nov. 10 1946

Immediate cause of death	DURATION
Diabetes Mellitis	
Due to —	
Due to —	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Thos. H. Phillips M. D. or other

Address: 1439 Edmondson Ave Balto MD Date signed: Nov 11 46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 10730

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45

1. PLACE OF DEATH:

County A.A

City or town Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Thirty Minuets

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Mayland County A.A.e.

City or town Parole
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Blanch E. Tayman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife Columbus Tayman

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) June II I889

8. AGE: Years	Months	Days	If less than one day
57	4	25	...hrs. ...min.

9. Birthplace Prince Geo County
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER 12. Name Robert Tayman

13. Birthplace Prince Geo County

MOTHER 14. Maiden name Rosie Cranford

15. Birthplace Prince Geo Conty

16. Informant Columbus Tayman

Address R.F.D. #I Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Nov8 I946 (month) (day) (year)

Cemetery or crematory Mt. Carmel

Location Upper Marlbro

18. Funeral director B.L.Hopping & Son

Address Annapolis, Maryland.

19. Nov. 7 19 46 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH November 5, 19 46 at 5.40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/1/46 19... to 11/5/46 19... and that I last saw her alive on November 5 19 46.

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions Arteriosclerotic-Cardio-Vascular disease	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Albert L. Anderson M.D.

M. D. or other

Address Annapolis, Md Date signed 11/5/46.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 84

CERTIFICATE OF DEATH

10731

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 40 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 910 McDonough St,
(If rural, give LOCATION)
2.(a) If veteran, name war: ------ ✓

3.(a) FULL NAME: Helen Minns Thomas

3.(b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Separated

6.(b) Name of husband or wife: *---------

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): February 2, 1902

8. AGE: Years	Months	Days	If less than one day
44	9	6	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ----

FATHER
12. Name: ----
13. Birthplace: ----

MOTHER
14. Maiden name: ----
15. Birthplace: ----

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal, Which?) Date thereof Nov. 13, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cemetery
Location: Anne Arundel County

18. Funeral director: Joseph Locks, Jr.
Address: 1304 N. Central Avenue
Baltimore, Maryland

19. Nov 11 1946 (Date rec'd by registrar) H.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 8 1946 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 30 1946 to November 8 1946 and that I last saw her alive on November 8 1946

Immediate cause of death	DURATION
Schizophrenia	known to us since Sept. 30, 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ----

Date of op. ----

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of —
Where did injury occur? ---- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ----
Means of injury ---- Injured at work? ----

23. SIGNATURE: Hubert V. Winterode M. D. or other
Address: Crownsville, Maryland Date signed Nov. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 10732

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yr., 3 mo., 27 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 9 yr., 3 mo., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. ------
(If rural, give LOCATION)

2.(a) If veteran, name war ------ ✓

3.(a) FULL NAME: MARGARET THOMAS

3.(b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: ------

6.(c) If alive, give age ------ years

7. Birth date of deceased (mo., day, yr.): 1915 ?

8. AGE: Years	Months	Days	If less than one day
31 ?	--	--	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: ------

FATHER — 12. Name: William Thomas

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Margaret Jackson

MOTHER — 15. Birthplace: Washington, D. C.

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof Nov. 9, 1946 (month) (day) (year)

Cemetery or crematory: Mt. Calvert

Location: Cedar Hill, Maryland

18. Funeral director: K. R. Williams

Address: 321 N. Schordor St., Balto.

19. Nov. 8 1946 (Date rec'd by registrar) A. H. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 5 1946, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 9 1937, to Nov. 5 1946

and that I last saw her alive on November 5 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis known to us since 7/9/37	
Due to	
Due to	
Other conditions: Schizophrenia Paranoid Type known to us since 7/9/37	

(Include pregnancy within 3 months of death)

Major findings of operation: ------

Date of op. ----

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of ----

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----

Means of injury ---- Injured at work? ---

23. SIGNATURE: Albert J. Winternitz M. D. or other

Address: Crownsville, Maryland Date signed 11/5/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

10733

Reg. Dist. No. 210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution? 12 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7 Second St. Parole Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Charity Tuddles

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Aaron Tuddles
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): July 18,1897

8. AGE: Years	Months	Days	If less than one day
49	4	0	...hrs. ...min.

9. Birthplace: Annapolis Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: None

FATHER
12. Name: William Wells
13. Birthplace: Anne Arundel Co.

MOTHER
14. Maiden name: Ida Queen
15. Birthplace: Anne Arundel Co.

16. Informant: Aaron Tuddles
Address: 7 Second St. Parole Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 11-21-1946 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street
18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. 11-21 (Date rec'd by registrar) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 18, 1946, at Emg. H.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7, 1946, to Nov. 18, 1946, and that I last saw h... alive on Nov. 18, 1946.

	DURATION
Immediate cause of death: Acute dilatation of the heart	Immediate
Due to:	
Due to:	
Other conditions: Arteriosclerotic Cardiovascular disease (Include pregnancy within 3 months of death)	1 yr.

Major findings of operation: ...
Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Albert L. Anderson M.D. M. D. or other
Address: Annapolis Md. Date signed 11/18/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

★ 10734

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural - Gambrills
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Crain Highway - nr. Anderson's corner

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Rural - Gambrills
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Wilson Woodrow Wells

3.(b) Social Security Number: 214-14-9227

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 22, 1912

8. AGE: Years	Months	Days	If less than one day
34	6	17	..... hrs. ..... min.

9. Birthplace: St. Marys County, Md.
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Jerman's Grocery, Gambrills,

FATHER — 12. Name: William Wells

FATHER — 13. Birthplace: Holland

MOTHER — 14. Maiden name: Laura Russell

MOTHER — 15. Birthplace: St. Marys County Md.

16. Informant: Mrs. Mavis Turner

Address: Gambrills, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 2, 1946 (month) (day) (year)

Cemetery or crematory: Our Lady of the Field

Location: Millersville, Md.

18. Funeral director: Thomas W. Dieghton

Address: Glen Burnie, Md.

19. Nov. 30 1946 (Date rec'd by registrar) Mrs. Alba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 Nov. 1946, at 8:20 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ 19 ..... to 19 .....

and that I last saw h alive on 19 .....

Immediate cause of death	DURATION
Crushing injury to head & Chest	
Due to	
Due to: Md.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: Nov 29, 1946

Where did injury occur? Crain Highway (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?): Highway

Means of injury: Automobile Injured at work? No

23. SIGNATURE: Edward P. Ritchings M.D. M.D. or other

Address: 199 Gloucester St. Annapolis, Md. Date signed: Nov 29, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-e)

CERTIFICATE OF DEATH

10735

Reg. Dist. No. 210

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 hours
Hospital, Institution, or street address where death occurred: Annapolis Emergency Hospital
How long in hospital or institution? 18 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infant, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Lothian
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War #1

3.(a) FULL NAME: Frank B. West.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Elsie Webb Marshall
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 14 1898

8. AGE:	Years	Months	Days	If less than one day
	48			..... hrs. ..... min.

9. Birthplace: Vesta, Patrick Co. Va.
(Town, county, and state)
10. Usual occupation: Medical Doctor Gen. Practice
11. Industry or business: Medicine
FATHER 12. Name: Spencer Wilson West
13. Birthplace: Patrick Co Va
MOTHER 14. Maiden name: Ruth E. Hylton
15. Birthplace: Floyd Co. Va.
16. Informant: Elsie B. West
Address: Lothian Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 21 1946 (month) (day) (year)
Cemetery or crematory: Arlington Cem. Va
Location: Arlington Virginia
18. Funeral director: L. C. Hardesty & Son
Address: Galesville Md.
19. 11/20/46 19..... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 19 1946, at 1:48 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~the information~~ from Post mortem Examination Nov. 19 1946

Immediate cause of death	DURATION
Due to: Fracture Base of Skull	
Due to: and Hemorrhage	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date of Nov. 18 1946
Where did injury occur? Greenock (City or town) A. A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: automobile collision Injured at work?

23. SIGNATURE: John M. Clatty M.D. Deputy Medical Examiner (M. D. or other)
Address: Annapolis, Md. Date signed: 11-19-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (58)

CERTIFICATE OF DEATH

Reg. Dist. No. 1 — 10736

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Hickory Point
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 86 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Hickory Point
(If outside city or town limits, write RURAL and give nearest town)

Street No. P. O. Pasadena, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: HELEN SALOME WILLIAMS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fem.	white	widowed

6.(b) Name of husband or wife: Herbert Williams

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 6, 1860

8. AGE: Years	Months	Days	If less than one day
86	9	18	..... hrs. ..... min.

9. Birthplace: A. A. Co., Md.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER
12. Name: John Dorsey Jacobs
13. Birthplace: Anne Arundel Co.

MOTHER
14. Maiden name: -Linstead
15. Birthplace: Anne Arundel Co.

16. Informant: Charles I. Williams
Address: P. O. Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 27 1946 (month) (day) (year)

Cemetery or crematory: Magothy Cem.

Location: A. A. County.

18. Funeral director: T. Singleton

Address: Glen Burnie Md.

19. 11-25 1946 (Date rec'd by registrar) Dr. L. A. Brei Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 24 1946, at 12 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26 1946, to November 24 1946 and that I last saw her alive on November 23 1946

Immediate cause of death	DURATION
Uremic coma	3days
Due to Chronic interstitial nephritis	10years
Due to	
Other conditions Carcinoma of right upper eyelid	1year

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: L. A. Brei, M. D.
M. D. or other

Address: Pasadena Md. Date signed: 11-24-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

I-35

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

CERTIFICATE OF DEATH

* 10737

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis 2nd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Annapolis Yacht Basin

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 923 Jackson St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Leonard S. Windsor

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Anna M. Windsor

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): June 26 - 1894

8. AGE: Years	Months	Days	If less than one day
52	5	2	hrs. min.

9. Birthplace: Annapolis Md (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER 12. Name: Fillmore Windsor

FATHER 13. Birthplace: Eastern Shore, Md

MOTHER 14. Maiden name: Henretta Ford

MOTHER 15. Birthplace: Wale, Md

18. Informant: Mrs. Theodore Burger

Address: 923 Jackson St Eastport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Nov. 30 1946 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md

18. Funeral director: W. H. Hopkins & Son

Address: Annapolis Md

19. Nov. 29 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Nov. 25 1946, about 10 P. M.

21. I CERTIFY that death occurred on the date above stated; ~~at the hour stated, from the cause(s) and~~ Postmortem Examination ~~in the manner stated below.~~ Nov. 28. 1946

Immediate cause of death	DURATION
Drowning	
Due to: Accidental	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: 11/25/46

Where did injury occur? Annapolis (City or town) A. A. (County) Md (State)

Injured at home, farm, industry, public place (where?) Yacht Basin

Means of injury: Fell off boat Injured at work? Yes

23. SIGNATURE: John N. Claffy M.D. Deputy Medical Examiner

Address: Annapolis, Md. Date signed: 11/29/46

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

16738

Reg. Dist. No. 212

1. PLACE OF DEATH:
County Anne Arundel
City or town Green Haven
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Green Haven
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: FRANK ~~ZIZZI~~ Zizzi

3.(b) Social Security Number: 216-01-0710

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Rose ~~Zizzy~~ Zizzi
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): March 10, 1890

8. AGE:

Years	Months	Days	If less than one day
56	8	7	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Coppersmith
11. Industry or business
FATHER 12. Name: Christopher Zizzi
13. Birthplace: Italy
MOTHER 14. Maiden name: Martha ?
15. Birthplace: Germany
16. Informant: Mrs. Rose Zizzi
Address: P. O. Pasadena, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 11/21/46 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Ritchie Highway
18. Funeral director: Frank Cowan
Address: 901 Hollins st., Balto., Md.
19. 11-17-46 (Date rec'd by registrar) L. A. Bratt, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: November 17, 1946, at 11 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..., 19..., to ..., 19...
and that I last saw him alive on Nov. 17, 1946

	DURATION
Immediate cause of death: Coronary thrombosis	1 day
Due to: Coronary sclerosis	?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings at operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. A. Bratt, M.D.
Address: Pasadena, Md. M. D. or other
Date signed 11-17-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-3 LE-1